DOCUMENT RESUME

ED 477 549 CG 032 403

TITLE	Building Bridges: An Act To Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration. Model Law and Commentary.
INSTITUTION	Bazelon Center for Mental Health Law, Washington, DC.
PUB DATE	2002-03-00
NOTE	38p.
AVAILABLE FROM	Bazelon Center for Mental Health Law, 1101 15th St, NW, Suite 1212, Washington, DC 20005. Tel: 202-467-5730; Fax: 202-223-0409; Web site: www.bazelon.org. For full text: http://www.bazelon.org/ issues/criminalization/publications/buildingbridges/BuildingBridges.pdf.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	EDRS Price MF01/PC02 Plus Postage.
DESCRIPTORS	*Laws; *Mental Disorders; Models; *Prevention; Prisoners; *Psychiatric Services; *Recidivism

ABSTRACT

Mental health advocates have been distressed for years about the disproportionate number of people with psychiatric disabilities who are arrested or held in jail or prison. Equally disturbing is the endless cycle of recidivism that results when people with psychiatric disabilities are released with their needs unmet. The Council of State Governments (CSG) recently completed two years of study and meetings of hundreds of individuals involved in criminal justice or mental health systems at the state and local levels. As the CSG found, "individuals with mental illnesses leaving prison without sufficient supplies of medication, connections to mental health and other support services, and housing are almost certain to decompensate, which in turn will likely result in behavior that constitutes a technical violation of release conditions or a new crime." This cycle can be broken, by ensuring that inmates with psychiatric disabilities have immediate access to the mental health services, housing and other supports they need to avoid rearrest. "Building Bridges" offers an approach that states can use to afford recently released inmates with psychiatric disabilities a successful transition to community life and provides a legislative template for enacting such policies. A summary of the model law is presented to provide a broad overview. In the succeeding sections, the text of the proposed legislation is paired with a commentary with background and explanation to assist advocates and policymakers in working to adapt the model to their state. The commentary highlights potential issues, explains the choices made as the language was drafted and provides references to helpful sources and supplementary materials. (GCP)

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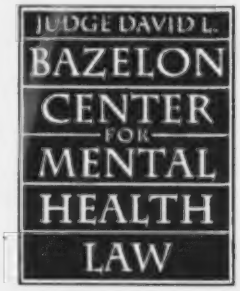

Building Bridges

An Act to Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration

· MODEL LAW AND COMMENTARY

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The Bazelon Center for Mental Health Law is the leading national legal-advocacy organization representing people with mental disabilities. Founded in 1972, the Washington D.C.-based nonprofit uses litigation, policy analysis, coalition-building and technical support for local advocates to advance and protect the rights of adults and children with mental illnesses or developmental disabilities and to promote their full participation in community life. Funding of this work comes primarily from grants by private foundations and gifts by generous individuals. For the development and distribution of this model law, we especially appreciate tbe support of the Open Society Insttitute's Center on Crime, Commmunities and Culture, the John D. and Catherine T. MacArthur Foundation and the Evenor Armington Fund.

BAZELON CENTER FOR MENTAL HEALTH LAW
1101 Fifteenth Street N.W., Suite 1212
Washington D.C. 20005-5002
(202) 467-5730 (voice); (202) 467-4232 (TDD); (202) 223-0409 (fax)
info@bazelon.org; www.bazelon.org

Building Bridges

An Act to Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration

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BUILDING BRIDGES
A Model Law

Introduction

The number of people with psychiatric disabilities in jails and prisons is on the rise. By the end of 2000, nearly one million adults with mental illnesses were in the criminal justice system.[1] Nearly two million new jail admissions were of people with mental illnesses—a rate of 35,000 individuals a week[2]—mostly for nonviolent offenses.[3] The number of youth with mental or emotional disorders entering juvenile detention centers and correctional facilities is also climbing.[4]

Mental health advocates have been distressed for years about the disproportionate number of people with psychiatric disabilities who are arrested or held in jail or prison. The growing numbers are also raising concern in criminal justice circles. Police express frustration about repeated—and time-consuming—encounters with people in their communities who appear in need of mental health treatment. Those who run jails, prisons and juvenile corrections programs worry about people with psychiatric disabilities in their facilities. They are concerned about these inmates themselves and about staff and other inmates, and outraged because these inmates need help more than—or instead of—punishment.

Equally disturbing—especially for the individuals themselves and their families—is the endless cycle of recidivism that results when people with psychiatric disabilities are released with their needs unmet. In these times of lean state budgets, lawmakers and public officials have raised serious concerns about the financial burden recidivism places on law enforcement, corrections and their community.

The Council of State Governments (CSG) recently completed two years of study and meetings of hundreds of individuals involved in criminal justice or mental health systems at the state and local levels.[5] As the CSG found, "individuals with mental illnesses leaving prison without sufficient supplies of medication, connections to mental health and other support services, and housing are almost certain to decompensate, which in turn will likely result in behavior that constitutes a technical violation of release conditions or a new crime."[6] This confirmed a 1991 study finding that within 18 months of release prom prison, 64 percent of offenders with mental illnesses were rearrested and 48 percent were hospitalized.[7]

This cycle can be broken, by ensuring that inmates with psychiatric disabilities have immediate access to the mental health services, housing and other supports they need to avoid rearrest. *Building Bridges* offers an approach that states can use to afford recently released inmates with psychiatric disabilities a successful transition to community life.

As the CSG recognized, people with psychiatric disabilities rely heavily on federal benefit programs to pay for housing, food and other necessities and to receive health and mental health services. Disability benefits such as Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) provide a cash benefit that is often essential to securing housing. Medicaid provides access to health, mental health care and substance abuse services. Although these are federal programs, states can put in place policies that will enable inmates with psychiatric disabilities to be enrolled or reinstated in these programs, receive needed services speedily and establish connections to the community-based mental health system prior to release. As the CSG noted, access to these services "is the most effective 'precontact' diversion from the criminal justice system for people with mental illness."[8] *Building Bridges* provides a legislative template for enacting such policies.[9]

How to Use the Model Law

A summary of the model law follows to provide a broad overview. In the succeeding sections, the text of the proposed legislation is paired with a commentary with background and explanation to assist advocates and policymakers in working to adapt the model to their state. The commentary highlights potential issues, explains the choices we made as the language was drafted and provides references to helpful sources and supplementary materials. We have assumed that states will want to enact implementing rules or regulations related to benefit-reinstatement legislation, and accordingly have included suggestions as to what those rules should contain.

Several states are already working with earlier drafts of this template. We hope many more will use *Building Bridges* to enact legislation that will address a critically important part of the growing crisis of serious mental illnesses. We urge advocates to form or join local task forces to discuss the issues and tailor the model law to fit state or local codes and circumstances. We welcome the opportunity to work with members of such task forces who are interested in adapting the law for enactment in their state.

1 Calculated using the respective rates of mental illness reported in Bureau of Justice Statistics Special Report, *Mental Health Treatment of Inmates and Probationers* (NCJ 174463) and year-end jail and prison population numbers reported in Bureau of Justice Statistics Bulletin, Prisoners in 2000 (August 2001, NCJ 188207) and probationers reported in Bureau of Justice Statistics press release of August 26, 20001.

2 Based on admission rates reported in Bureau of Justice Statistics Bulletin, Census of Jails, 1999 (August 2001, NCJ 186633) multiplied by the percentage of jail inmates with a mental illness (16.3%) reported in Bureau of Justice Statistics Special Report, *Mental Health Treatment of Inmates and Probationers* (July 1999, NCJ 174463).

3 Bureau of Justice Statistics Special Report, *Mental Health Treatment of Inmates and Probationers* (NCJ 174463)(citing a figure of 70 percent).

4 Cocozza, Joseph. J., & Skowyra, Kathleen R. Youth with Mental Health Disorders: Issues and Emerging Responses (April 2000). *Juvenile Justice*, Volume VII(1), Washington DC: Office of Juvenile Justice & Delinquency Prevention.

5 Council of State Governments , Criminal Justice/Mental Health Consensus Project (June 2002), New York: Council of State Governments. The report may be found at www.consensusproject.org.

6 *Id.* at p. 274.

7 Feder, L., "A profile of mentally ill offenders and their adjustment in the community," *Journal of Psychiatry and the Law*, 19:79-98 (1991).

8 Council of State Governments at p. 33; Id at p. 274 ("Linkage with appropriate government benefits in a timely manner can make the difference between success and failure in the community.").

9 The Bazelon Center for Mental Health Law has authored several publications focusing on individuals with serious mental illnesses in the criminal justice system and their return to the community following incarceration. These include *Finding the Key to Successful Transition from Jail to Community* (March 2001), an explanation of federal Medicaid and Disability Program (SSI, SSDI) rules; *Facts about Federal Benefits for Individuals with Serious Mental Illnesses Who Have Been Incarcerated: Veterans Benefits, Temporary Assistance for Needy Families (TANF) and Food Stamps* (January 2002); *Fact Sheets for Advocates: People with Serious Mental Illnesses in the Criminal Justice System* (May 2002); and *A Better Life—A Safer Community: Helping Inmates Access Federal Benefits* (February 2003).

An Act to Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration

Section-by-Section Summary

Article I

Sets out findings and explains the purposes of the bill. When released from jail or prison, individuals with psychiatric disabilities often lack access to critical services and supports such as health and mental health care, housing, education and employment or income support. As a result, many become trapped in a cycle of destitution, deterioration, rearrest and re-incarceration. Although federal entitlement programs offer income support and health care coverage, individuals released from incarceration seldom have timely access to these benefits. The Act directs state and local agencies to adopt policies and procedures that enable individuals with psychiatric disabilities, upon release, to be enrolled or reinstated in these programs, receive needed services speedily and establish connections to the community-based mental health system prior to release. By thus promoting the successful community re-entry of inmates with psychiatric disabilities, the Act will enhance public safety and offer taxpayers relief from the fiscal burdens imposed by avoidable recidivism.

Article II

Defines terms used in the bill.

Article III.

Establishes state policy to facilitate suspension, rather than termination, of federal benefits when an individual with psychiatric disabilities is incarcerated and to enable speedy restoration of benefits upon the individual's release.

Article IV

Establishes state policy to assist inmates with psychiatric disabilities who are not on eligibility rolls for federal entitlements in applying, while incarcerated, to receive benefits upon release. Requires the Medicaid agency to set up procedures for receiving Medicaid applications and reviewing them within 14 days and enrolling eligible individuals on suspended status while incarcerated. Mandates that correctional agencies identify inmates who are likely to be eligible for Medicaid and/or disability benefits, ask them if they wish to apply and ensure that applications are filed well in advance of their release.

Article V

Requires correctional agencies to negotiate Pre-Release Agreements with the Social Security Administration and to arrange for competent and experienced staff to assist inmates with psychiatric disabilities in applying for federal disability benefits prior to their release.

Article VI

Creates a bridge program for released inmates whose applications for federal benefits are pending. Requires the state Medicaid agency to provide a temporary Medicaid card and cover services for up to six (6) months or until an individual is determined ineligible. Designates a state agency to provide temporary income support for up to six (6) months to individuals with psychiatric disabilities who have applied for but are not receiving SSI or SSDI upon release. Provides for the state to claim federal reimbursement of benefits provided to the individual and prohibits the recovery of any costs from an individual who is found ineligible for federal entitlements.

Article VII

Requires correctional agencies to arrange for the issue of a photo identification card that does not disclose the individual's incarceration.

Article VIII

Requires access to medically necessary mental health services for inmates both while incarcerated and upon release. Assigns this responsibility to the state corrections agency for individuals in prison who have psychiatric disabilities, to the state juvenile corrections agency for individuals in juvenile corrections facilities, and to the state mental health agency for inmates in jails or juvenile detention facilities. Mandates the provision of an adequate temporary supply of medication upon an inmate's release and requires the state mental health agency to provide case management services well in advance of an inmate's release to help arrange for shelter, services and supports and assist with benefit applications.

Article IX

Requires the state Medicaid agency to seek federal approval of amendments to the state Medicaid plan that may be necessary to implement this legislation.

Article X

Appropriates funding to implement the Act.

Article XI

Sets dates when the various articles will take effect.

Building Bridges

An Act to Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration

MODEL LAW AND COMMENTARY

Commentary on Article I

I. A. Findings.

The Findings section includes general statements about the importance of access to income and health care benefits for individuals with psychiatric disabilities who are returning to their communities following incarceration. It may be helpful to include supporting data either in the Findings section of the legislation or in fact sheets distributed to lawmakers.

National studies show that many incarcerated individuals have psychiatric disabilities. For example, researchers have found that:

- More than 16% of jail inmates have a mental illness.[1]
- Annually, nearly two million people with mental illnesses are jailed-35,000 new admissions a week.[2]
- At the end of 2000, nearly one million individuals with mental illnesses were incarcerated or on probation.[3]
- Youth in the juvenile justice system have substantially higher rates of mental health disorders than youth in the general population.[4]
- One in five youth in the juvenile justice system has a serious mental health problem.[5]

More than 600,000 individuals will be released from prisons this year, at least 1,600 per day; many more will be released from jails and juvenile facilities.[6]

Every former inmate faces obstacles in finding work, re-establishing family relationships, developing a social network and avoiding further criminal activity, but the challenges faced by individuals with psychiatric disabilities-who require specialized services and supports -can be even greater and more complex. In addition to grappling with

Article I: Findings and Purpose

A. Findings

The Legislature finds and declares that:

1. When released from incarceration, adults and juveniles with psychiatric disabilities often lack access to mental health services, stable housing, employment or other income and education. Obtaining food and other necessities can be a problem. Without basic supports, many needlessly become trapped in a cycle of destitution, deterioration, rearrest and re-incarceration.

2. Upon release, individuals with psychiatric disabilities need basic services and supports to enable them to transition successfully to community life. Existing federal programs, such as Medicaid, Supplemental Security

Income (SSI) and Social Security Disability Insurance (SSDI), provide health care coverage and income support to people with psychiatric disabilities. Often, however, individuals released from incarceration are not enrolled in these programs or their enrollment is unreasonably delayed.

3. Legislative action is required to aid individuals with psychiatric disabilities in maintaining their eligibility for federal benefit programs during incarceration and, upon release, to enable them to access federal benefit programs for which they are eligible and temporary health care coverage and income when federal benefits are not immediately available.

4. Legislative action is also required to ensure that, upon release, individuals with psychiatric disabilities are connected to the community-based mental health system.

5. Providing access to mental health care and income support for individuals with psychiatric disabilities upon their release will promote successful community re-entry, enhance public safety and provide relief to taxpayers from fiscal burdens imposed by avoidable recidivism.

B. Purpose

The purpose of this Act is to facilitate the community reintegration of adults and juveniles with psychiatric disabilities upon release from jail, prison,

their illnesses, they are more likely than other inmates to have been homeless or unemployed when incarcerated. For example, within the year before arrest:

- Twenty percent of state prisoners with mental illnesses were homeless, compared to 9% of other inmates.
- Thirty percent of jail inmates with mental illnesses were homeless, compared to 17% of other inmates.
- Thirty-nine percent of state prisoners with mental illnesses were unemployed, compared with 30% of other inmates.[7]

Linking individuals with necessary services and supports as soon as possible after release is important to prevent recidivism. Research shows that the first weeks in the community are critical, with arrest rates highest soon after release and declining over time.[8]

As the Vera Institute notes, the first month out "is not only a period of difficulties, but also a period of opportunities to get people started on the path to employment, abstinence from drugs, good family relations, and crime-free living."[9] We fail to take advantage of these opportunities. For example, a 1991 study reported that 64% of offenders with mental illnesses were rearrested within 18 months of release from incarceration and 48% were hospitalized one or more times within those first 18 months.[10]

State-specific statistics, if available, can be especially helpful to convince legislators of the need for and cost-effectiveness of improving released inmates' access to benefits and services. For example,

- The number of individuals incarcerated in the jurisdiction can be gathered. In many places, estimates of the number of inmates with psychiatric disabilities are available or discernable. The number of individuals released annually from state prisons or local jails should also be available.
- Data on the number of inmates in the state who received Supplemental Security Income (SSI) or Medicaid at the time of incarceration should be obtainable.[11]
- Typical wait times for Medicaid and SSI eligibility determinations or redetermination are also available. This sort of data can be very useful in describing and making real the challenges faced by released inmates with psychiatric disabilities.[12]

I. B. Purpose.

This model law proposes specific actions that states and localities can take to improve access to federal Medicaid, SSI and SSDI[13] benefits for adults and juveniles with psychiatric disabilities being released from correctional

facilities. According to the landmark consensus report from the Council of State Governments (CSG), it is important to "streamline administrative procedures to ensure that federal and state benefits are reinstated immediately after a person with mental illness is released..."[14] The CSG consensus report recommends that states suspend Medicaid benefits, as opposed to terminating them, commence discharge planning at the time of booking and continue the process throughout the period of detention, and develop a process to ensure that inmates who are eligible for public benefits receive them immediately upon their release.

Advocates and policymakers should also consider including in legislation improved access to other federal benefit programs that can help individuals more successfully reintegrate into their communities, such as Temporary Assistance to Needy Families (TANF), Food Stamps, and Veterans Administration benefits and health coverage, as well as state only public assistance programs such as general assistance.[15]

In addition to being humane and a cost-effective, helping individuals with psychiatric disabilities to access these benefits upon release can be part of a more comprehensive state approach to support community integration. Under the Supreme Court's ruling in *Olmstead v. L.C.*,[16] states must avail themselves of all resources that can be used to support an individual with a disability living in the community. Failure to assist people being released from correctional facilities in quickly accessing federal Medicaid, disability and other benefits to which they are legally entitled undermines a state's ability to achieve the community integration mandate of the Supreme Court's ruling in *Olmstead*.

While the model law is drafted as a state law, it could be adapted to be local legislation, for enactment by a county or city. Localities cannot change Medicaid rules or regulate mental health care in state facilities, but they could implement other provisions of this law. The Bazelon Center can help advocates and policymakers interested in drafting local legislation.

1. Bureau of Justice Statistics Special Report, *Mental Health Treatment of Inmates and Probationers* (July 1999, NCJ 174463). This statistic and additional data can be found in the Bazelon Center's Fact Sheets for Advocates: People with Serious Mental Illnesses in the Criminal Justice System, at www.bazelon.org.

2. Based on admission rates reported in Bureau of Justice Statistics Bulletin, Census of Jails, 1999 (August 2001, NCJ 186633) multiplied by the percentage of jail inmates with mental illnesses (16.3%) reported in Bureau of Justice Statistics Special Report, *Mental Health Treatment of Inmates and Probationers* (July 1999, NCJ 174463).

3. Calculated using the respective rates of mental illness report in Bureau of Justice Statistics Special Report, *Mental Health Treatment of*

detention centers or other correctional facilities and to enhance public safety and provide cost-effective care by enabling such individuals to receive benefits speedily upon their release from incarceration. It directs [identify state and local agencies] to adopt policies and procedures that enable individuals with psychiatric disabilities, upon release from incarceration, to:

1. participate in federal benefit programs for which they qualify;

2. be speedily reinstated or enrolled in federal health insurance and income support programs for which they are eligible;

3. obtain temporary health care coverage and income support while receipt of federal benefits is pending; and

4. receive mental health services, including case management, medications and substance abuse services.

This Act also provides funds for costs associated with its implementation.

Inmates and Probationers (July 1999, NCJ 174463) and year-end jail and prison population numbers reported in Bureau of Justice Statistics Bulletin, Prisoners in 2000 (August 2001, NCJ 188207) and probationers reported in Bureau of Justice Statistics press release of August 26, 2001.

4. Cocozza, Joseph. J., & Skowyra, Kathleen R., Youth with Mental Health Disorders: Issues and Emerging Responses (April 2000), *Juvenile Justice*, Vol. VII(1), Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention.

5. *Id.*

6. Travis, Jeremy, Solomon, Amy L. & Waul, Michelle , *From Prison to Home: The Dimensions and Consequences of Prison Reentry*, Research Monograph of the Justice Policy Center of The Urban Institute (June 2001).

7. Bureau of Justice Statistics Special Report, *Mental Health Treatment of Inmates and Probationers* (July 1999, NCJ 174463).

8. See Nelson, M., Deess, P., & Allen, C. *The First Month Out, Post-Incarceration Experiences in New York City* (New York, New York: Vera Institute of Justice, 1999) at 2-3; Beck, A. & Shipley, B. *Recidivism of Prisoners Released in 1983*, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 1989. (These arrests resulted in about 41% being back in jail or prison within three years.) Another study published in 2000 by the Bureau of Justice Statistics found that 62% of individuals who leave jail or prison each year are re-arrested at least once within three years and 41% are re-incarcerated. Beck, A. J., *State and Federal Prisoners Returning to the Community: Findings from the Bureau of Justice Statistics*, Washington DC: United States Department of Justice, Bureau of Justice Statistics (2000).

9. Nelson, Deess & Allen (1999) at 2.

10. Feder, L., "A profile of mentally ill offenders and their adjustment in the community," *Journal of Psychiatry and the Law*, 19:79-98 (1991). The study looked at prison inmates who had required psychiatric hospitalization during incarceration. See also Feder, L., "A comparison of the community adjustment of mentally ill offenders with those from the general population: An 18-month follow-up," *Law and Human Behavior*, vol. 19, no. 5 at 477 (1991).

11. It is especially true for SSI statistics because most jails report this information to the Social Security Administration in order to collect a "incentive payment" or bounty fee from SSA. See 42 U.S.C. § 402(x); POMS SI 02310.088. "POMS" refers to the Social Security Administration's Program Operations Manual System, available online at SSA's website, http://policy.ssa.gov/poms.nsf.

12. In New York, for example, advocates determined that the Medicaid re-application process takes two to three months or more; more than 28,000 people were released from New York State prisons and 100,000 were released from local jails in 2000, and an estimated 25-30% of all New York state inmates receive Medicaid at the time of their incarceration. From these data, they could extrapolate that because of Medicaid-eligibility terminations and delays in reinstatement, more than 40,000 individuals in the state were released from incarceration and could not get the immediate health care services to which they are entitled. Letter from Mental Health Association of New York State to Antonia Novello, Commissioner, New York Department of Health, November 21, 1901.

13. The model law does not directly address Medicare. Individuals gain access to Medicare through enrollment in the SSDI program; they are entitled to Medicare benefits (although not while incarcerated) after two years of enrollment in the SSDI program. By facilitating access to SSDI, states also facilitate access to Medicare. Unfortunately, Medicare is of little benefit to released inmates seeking mental health services. It does not pay for medications, a deficiency that Congress may eventually correct, nor does it pay for intensive community services. But it does have limited coverage for counseling and hospitalization.

14. Council of State Governments, Criminal Justice/Mental Health Consensus Project (June 2002), New York: Council of State Governments, available at www.consensusproject.org , Policy Statement 12(a) at p. 99 and Policy Statement 16(b) at p. 121, *id.* at Policy Statement 21(g) at p. 168 ("[states should] Develop a process to ensure that inmates eligible for public benefits receive them immediately upon their release.").

15. See *Facts About Federal Benefits for Individuals with Serious Mental Illness Who Have Been Incarcerated: Veterans Benefits, Temporary Assistance for Needy Families (TANF) and Food Stamps* (January 2002), and *A Better Life-A Safer Community: Helping Inmates Access Federal Benefits* (January 2003), available at www.bazelon.org/issues/criminalization. The Council of State Governments report urges that states "[e]nsure that people with mental illness are accessing the full range of entitlements for which they are eligible." Policy Statement 39(c) at p. 474.

16. *Olmstead v. L.C.*, 527 U.S. 581 (1999). See Bazelon Center for Mental Health Law, *Under Court Order— What the Community Integration Mandate Means for People with Mental Illnesses: The Supreme Court Ruling in Olmstead v. L.C.* (October 1999). Available at www.bazelon.org/issues/communitybased/olmstead/lcruling.htm

Commentary on Article II

Definitions should, when appropriate, reference and be consistent with existing definitions in state law or regulation. Specific definitions in the model law make reference to existing state definitions.

Case management: This definition should at a minimum include helping individuals to access programs, services and supports (including housing, education, employment, job training, social services, legal services and health care), as well as individual client advocacy to establish and maintain eligibility for benefits and other programs and to uphold clients' rights.

Individuals with psychiatric disabilities: This definition identifies the population to which the law will apply. As written, the law targets adults with serious mental illnesses and juveniles with emotional or behavioral disturbances, as defined in state law or policy. The target population can be expanded or limited by adopting an alternative definition. In defining the target population, drafters may want to consider an approach taken by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), which defines an individual with a psychiatric disability as someone with an illness listed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM)[1] that substantially interferes with or limits one or more major life activities.

Incarcerated and Inmates: Federal law prohibits Medicaid payments for "care or services" for any individual who is an "inmate" in a correctional facility.[2] An individual is an inmate of a correctional facility if held there involuntarily. Status offenders and adults or juveniles awaiting transfer, trial or sentencing are all "inmates" on whom Medicaid dollars may not be spent. An individual is not "incarcerated" or an "inmate" if on probation, parole or home monitoring[3] and, accordingly, may receive care and services paid by Medicaid.[4]

Likely to be eligible: The model law provides that previous enrollment within five years of incarceration makes an individual "likely to be eligible" upon release. Otherwise, the model law does not detail how the state will determine if inmates are "likely to meet eligibility criteria for the Medicaid, SSI or SSDI programs upon their release from incarceration." Advocates and policymakers may wish to include additional guidance in the law or a specific direction that regulations be developed to give additional guidance. Such guidance might focus on whether the individual has a mental illness diagnosis, meets a certain standard of

Article II: Definitions

1. "Case management" means [see state law and policy]

2. "Correctional agency" means an agency of state or local government responsible for overseeing the operation of one or more correctional institutions, including juvenile justice facilities.

3. "Correctional institution" means a jail, prison, juvenile corrections facility, juvenile detention facility or other detention facility operated by a state or local correctional agency that qualifies as a public institution under 42 Code of Federal Regulations (C.F.R.) § 435.1009.

4. "Enrolled in the SSI program" means (a) currently eligible, as determined by the Social Security Administration pursuant to SSI program rules and (b) on eligibility rolls, even if cash benefits are currently suspended.

5. "Enrolled in the SSDI program" means (a) currently eligible, as determined by the Social Security Administration pursuant to SSDI program rules and (b) on eligibility rolls, even if cash benefits are currently suspended.

6. "Federal benefit programs" refers to Medicaid, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

7. "Incarcerated" means confined in a correctional institution.

8. "Individuals with psychiatric disabilities" includes (a) adults with serious mental illnesses, as defined in [state law or policy], and (b) juveniles with emotional/behavioral disturbances or emotional disorders, as defined in [state law or policy].

9. "Inmates" refers to incarcerated individuals with psychiatric disabilities.

10. "Likely to be eligible" individuals means individuals with psychiatric disabilities (a) whose enrollment in the Medicaid, SSI or SSDI program was terminated during their incarceration; (b) who were enrolled in the Medicaid, SSI or SSDI program at any time during the five years prior to their incarceration; or (c) who were not previously enrolled, but who are likely to meet eligibility criteria for the Medicaid, SSI, or SSDI programs upon their release from incarceration.

11. "Medicaid eligibility category" refers to all existing eligibility categories established in the state Medicaid plan

12. "Medicaid eligibility through SSI" means that an individual is eligible to participate in the Medicaid program by virtue of enrollment in the SSI program.

13. "Mental health services" means [see state law and policy]. It includes substance abuse services.

14. "Parent" means a parent, guardian or individual acting in the role of parent (*e.g.*, grandparent raising a child).

disability and is low income.

Under the model law, "likely to be eligible" individuals receive help in applying for federal benefits upon release and are eligible for bridge programs (Article VI). In fleshing out the definition, policymakers should keep in mind that the state has an interest in reducing its overall expenses and those of localities and in shifting costs to the federal government.[5] When individuals are released without benefits and deteriorate, they end up in emergency rooms, psychiatric hospitals and jails, where care is expensive and is paid for primarily by state and local dollars. Some less expensive community care may be available, also without federal cost-sharing. It makes fiscal sense to ensure that released inmates are enrolled in federal benefit programs or in bridge programs that enable them to receive less expensive community services, whose costs can be recouped with federal funds.

Medicaid provides access to health and mental health treatment, including services that help maintain housing or a job or continue their education. Medicaid also funds case managers, who will assist the person in addressing problems of daily living. Medicaid is a means-tested program and has other specific eligibility criteria. Released inmates with psychiatric disabilities will usually qualify for Medicaid as a consequence of enrollment in the SSI program or because they are low income and care for a child.

In all states, the federal government pays at least 50% of the cost of the Medicaid program. The actual share of costs paid by the federal government depends on the economic well-being of the state's population: the poorer the state, the higher the proportion of costs paid by the federal government. In the poorest states, the federal government pays over 75% of the cost of Medicaid services.[6]

Medicaid eligibility category: This definition is written to encompass all of the eligibility categories in the state's Medicaid plan, both those mandated by federal law and those that are optional. Using this language ensures the inclusion of all individuals who may be eligible for Medicaid. Some of the relevant optional eligibility categories are:

- Women and children in families whose incomes are over the federally mandated minimum of 100% of the federal poverty level (states have flexibility to set income limits up to 185% of federal poverty level).[7]
- Medically needy individuals, defined as those who do not meet the financial eligibility criteria of Medicaid but who have high health care expenditures and who can be eligible once they spend down to Medicaid-eligibility

levels (calculated by deducting their health care expenses from their incomes).[8]

- Individuals with disabilities who receive SSI state supplements but are not eligible for SSI cash benefits because their income is over the federal limit.[9]
- Individuals ages 65 and over and people with disabilities with incomes up to 100% of poverty.[10]
- Those who will be working upon release but who also have a disability (in some cases they must buy into the program).[11]
- Young adults who were in foster care on their 18th birthday but have since aged out (they can be covered under Medicaid up to age 19, 20 or 21).[12]
- Individuals who qualify for Medicaid through a state's Section 1115 waiver program to cover uninsured individuals.[13]
- Juveniles who are eligible for coverage because they have coverage under the State Children's Health Insurance (S-CHIP) program, which in many states provides them access to Medicaid. (Note that in some states, S-CHIP youngsters will only be eligible for a limited private insurance health plan.)[14]

Mental health services: Under the model law, "mental health services" is defined to include substance abuse services. An alternative would be to use throughout the law the term "behavioral health" services, defined to include both mental health and substance abuse services. Because of the high incidence of substance abuse among individuals with psychiatric disabilities who end up incarcerated, it is essential that the model law provide for access to substance abuse services.

Pre-Release Agreement: A pre-release agreement is an agreement between the Social Security Administration (SSA) and a correctional agency that details how SSA and the agency will work together to access SSA's "pre-release procedure" on behalf of incarcerated individuals. SSA's pre-release procedure is aimed at "assuring eligible individuals timely SSI payments when they reenter the community."[15] This procedure allows SSA to (a) process SSI applications from incarcerated individuals months before their anticipated release and (b) make a prospective determination of potential eligibility and payment amount, based on anticipated circumstances. Through this approach, benefits are payable as soon as feasible after—sometimes even on the day of—release.

A pre-release agreement can apply to one correctional facility, a group of facilities or all facilities in a jurisdiction.

Pre-release agreements may also be used to improve

15. "Pre-Release Agreement" means a formal agreement with the Social Security Administration (SSA) under which a correctional agency and SSA will work collaboratively to ensure that applications for SSI and SSDI by inmates are speedily handled by SSA.

16. "SSI" means the Supplemental Security Income program, a federal income support program for people with disabilities and low incomes, provided under Title XVI of the Social Security Act.

17. "SSDI" means the Social Security Disability Income program, a federal income support program, provided under Title II of the Social Security Act, for individuals with disabilities who have worked and paid Social Security taxes.

18. "Suspend" Medicaid coverage means to place an individual's Medicaid eligibility in an inactive status such that (a) the individual remains eligible for Medicaid and continues on the state rolls but (b) Medicaid benefits are not payable for services furnished (e.g., during incarceration).

19. "Suspend" SSI or SSDI eligibility means to stop cash payments due to incarceration.

access to SSDI and Food Stamps.

Note: SSA's pre-release procedure can be utilized without a pre-release agreement.[16]

For a more detailed description of pre-release agreements, see the commentary for Article V.

SSI: The federal Supplemental Security Income program provides income support to low-income individuals who are aged, blind or disabled. Individuals who qualify for SSI benefits are generally eligible automatically for Medicaid.[17] To be eligible for SSI on the basis of disability, individuals must have a diagnosed disorder, such as mental illness. Adults must be so disabled that they cannot engage in "substantial gainful activity" by working in any job that is available in the national economy. Juveniles must have "marked and severe" functional limitations when compared with other children of the same age.

SSDI: Social Security Disability Insurance pays monthly benefits, based on past earnings, to individuals with disabilities who have been employed. Most people with serious mental disorders are on SSI (either alone or in combination with a small SSDI benefit) because they have a limited work history due to the severity of their illness and the young age at which they became disabled. Recipients become automatically eligible for Medicare health and mental health care benefits two years after they qualify for SSDI.

1. The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association sets the criteria for diagnosis of a psychiatric condition.

2. 42 U.S. Code § 1396d(a)(27)(A).

3. POMS SI 00520.009 ("Individuals participating in alternatives to incarceration outside of formal institutional settings for whom the penal authorities are *not* providing food and shelter (either directly or indirectly) are not residents of a public penal institution."). "POMS" refers to the Social Security Administration's Program Operations Manual System, available online at SSA's website, http://policy.ssa.gov/poms.nsf.

4. See 42 C.F.R. § 435.1009.

5. See The Biennial Report of the Texas Council on Offenders with Mental Impairments (2003) at 26-28 (describes a Social Security project between SSA and TCOMI that has as one of its goals decreasing local and/or state financial burden following an individual's release from jail). TCOMI's programs are being studied by Sam Houston State University.

6. POMS SI 01715.001 B ("The Federal government pays 50 percent of Medicaid administrative costs and between 50 and 83 percent of program costs following a statutory cost-sharing formula.").

7. 42 U.S.C. §1396a(10)(E)(iii).

8. 42 U.S.C. §1396a(a)(10)(C), 42 C.F.R. § 435.300, § 435.800, §436.800.

9. 42 U.S.C. §1396a(a)(10)(A)(ii)(XII); 42 C.F.R. § 435.232.

10. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XI).

11. 42 U.S.C. §1396a(a)(10)(A)(ii)(XV, XIII and XVI), §1360(g), §1396b(i)(20), §1396d(v), §1396a(u)(1).

12. 42 U.S.C. §1396a(a)(10)(A)(ii), §1396d(v) and 42 C.F.R. § 435.222(b)(1).

13. Section 1115 of the Social Security Act, 42 U.S.C. § 1315(a).

14. Title XXI of the Social Security Act, added by the Balanced Budget Act of 1997, Pub. L. No. 105-33, Subtitle J, State Children's Health Insurance Program, and 42 C.F.R. § 457.

15. POMS SI 00520.900 A. For an example of a pre-release agreement, see POMS SI 00520.930, exhibit 2.

16. POMS SI 00520.910 ("a formal agreement is not a prerequisite for utilizing prerelease [procedures]").

17. In 32 states, SSI eligibility results in automatic Medicaid coverage; in seven other states, SSI recipients are automatically eligible for Medicaid but must submit a separate application. In the 11 states that use different rules (CT, HA, IL, IN, MN, MS, NH, ND, OH, OK and VA), people who receive SSI nearly always qualify for Medicaid, although they must go through a separate application process.

Commentary on Article III

The model law sets up a three-pronged approach for inmates who were enrolled in federal benefit programs at the time they were first incarcerated:

- inmates retain benefit eligibility status as long as permitted under federal law;
- restoration of suspended benefits is immediate upon release; and
- inmates receive assistance with applications for restoration of benefits, as set forth in Article V.

Article IV applies when federal benefits have been terminated, or when a likely-to-be-eligible individual had no previous enrollment in SSI, SSDI or Medicaid.

III. B. 1. Suspension of Medicaid Benefits

Federal Medicaid benefits are essential to most jail inmates with psychiatric disabilities who leave corrections facilities through discharge, parole or conditional release/probation. If they are to access community treatment services, these individuals need speedy access to Medicaid mental health coverage. The Vera Institute's study of post-incarceration experiences in New York City found that the lack of Medicaid was the biggest obstacle to accessing treatment (psychiatric treatment, addiction treatment or medical treatment) following release from incarceration.[1]

Federal law prohibits Medicaid payments for "care or services" for any individual who is an inmate in a correctional facility.[2] However, state officials are permitted "to use administrative measures that include temporarily suspending an eligible individual from payment status during the period of incarceration to help ensure that no Medicaid claims are filed."[3] **States are not required to terminate an individual's Medicaid eligibility upon incarceration.**[4] In fact, the states have no authority under Medicaid law to drop inmates from the Medicaid eligibility rolls upon incarceration.[5]

Nonetheless, in most if not all states, when a Medicaid recipient is incarcerated, the Medicaid agency is notified of the incarceration and automatically terminates the individual's Medicaid eligibility.[6] The individual is required to re-apply for Medicaid when released and must await an eligibility determination before getting Medicaid benefits and renewed access to treatment services. The Medicaid re-application process is often cumbersome and lengthy. The Council of State Governments Consensus Project urges states to "[s]uspend (as opposed to terminate) Medicaid benefits upon the detainee's admission to the facility to

Article III: Suspension of Eligibility Upon Incarceration and Restoration Upon Release

A. State Policy

It shall be the policy of [State] to facilitate, to the full extent permitted by federal law:

1. the suspension rather than termination of federal benefits when an individual with psychiatric disabilities is incarcerated, and

2. speedy restoration of benefits upon the individual's release.

B. Medicaid

The [Medicaid agency] shall adopt regulations or policies ensuring that:

1. When an individual with psychiatric disabilities enrolled in the Medicaid program is incarcerated,

   a. the individual's eligibility for Medicaid will be suspended rather than terminated, and will remain suspended rather than terminated for as long as is permitted by federal law; and

   b. the individual shall not be terminated from the Medicaid program unless [Medicaid agency] determines that the individual (i) no longer meets the Medicaid eligibility criteria under which they had qualified and (ii) is not eligible for Medicaid under any other Medicaid eligibility category.

2. When an individual whose Medicaid eligibility is suspended is released from incarceration, the individual's Medicaid eligibility will be fully restored on the day of release unless and until the [Medicaid agency] determines that the individual is no longer eligible for Medicaid.

C. Federal Disability Benefits

[Correctional agencies] shall seek to ensure the speedy restoration of benefits of inmates with psychiatric disabilities whose eligibility for SSI or SSDI has been suspended during incarceration. These agencies shall seek to ensure that cash benefits under SSI and SSDI are reinstated in the month of release. To this end, these agencies shall:

1. identify inmates with psychiatric disabilities whose SSI or SSDI was suspended during incarceration, and ask them if they wish to receive benefits when released, and

2. for those who wish to receive benefits, ensure that (i) applications for reinstatement of SSI or SSDI upon release are filed on their behalf as soon as possible following suspension, and (ii) all applicants for reinstatement leave the correctional institution with a copy of the application.

ensure swift restoration of the health coverage upon the detainee's release."[7]

III. B. 2. Reinstatement of Medicaid

When Medicaid benefits have been suspended, they must be fully restored immediately upon release. As the Secretary of HHS recently made clear, "a State must ensure that the incarcerated individual is returned to the rolls immediately upon release, unless the State has determined that the individual is no longer eligible for some other reason."[8] This allows released individuals to go directly to a Medicaid provider and access services.[9]

When Medicaid Eligibility Is Dependent on SSI Eligibility. Many inmates with psychiatric disabilities are eligible for SSI and through that eligibility qualify for Medicaid.[10] When an inmate whose Medicaid eligibility is through SSI is terminated from SSI, he or she will lose Medicaid eligibility unless qualified for Medicaid under another eligibility category.[11] When an individual's Medicaid eligibility is wholly dependent on SSI, SSI eligibility must be restored first before Medicaid eligibility can be restored. SSA's pre-release procedure can greatly speed the individual's re-establishment of SSI eligibility. (See Commentary on Article V.B. regarding pre-release agreements and the importance of close work between correctional agencies and the Social Security Administration).

III. C. Applications to Restore Federal Disability Benefits

This section sets up processes by which correctional agencies are to ensure the speedy restoration of SSI and SSDI cash benefits upon release for individuals with psychiatric disabilities whose benefits were suspended during incarceration.

SSI cash payments are suspended when an individual is incarcerated for a full calendar month.[12] The inmate remains on the eligibility rolls, and SSA presumes that the inmate, while incarcerated, remains disabled.[13] This situation continues unless and until the inmate has experienced consecutively 12 full calendar months of incarceration. If the inmate is incarcerated consecutively for 12 full calendar months, SSI eligibility is terminated.[14] An individual whose eligibility has been terminated must file a completely new application for SSI, and show that he or she is still disabled under the eligibility standards (see Article IV).

SSDI cash payments are also suspended when an individual has been convicted of a felony and incarcerated for longer than 30 days.[15] However, SSDI eligibility is never

terminated for incarceration alone, no matter how long the incarceration.[16] Cash payments can resume the month after the month of release.[17] SSA must verify that the person is no longer in a correctional facility.

By taking advantage of SSA's pre-release procedure, states can assure speedy restoration of SSI and SSDI benefits upon an inmate's release. (See Commentary to Article V.B.)

1. Nelson, M., Deess, P., and Allen, C. *The First Month Out, Post-Incarceration Experiences in New York City.* New York, New York: Vera Institute of Justice, 1999 at p. 21. ("Some people told us they worried about running out of medication, and a few reported skipping doses to make their medication last longer, hopefully until they were covered. . . . Delays in getting Medicaid meant that many people who were required to attend a treatment program could not enroll immediately, which put them at risk of relapsing and of violating parole.").

2. The Medicaid statute precludes payment of federal matching funds to pay for services for an individual wo is "an inmate of a public institution (except as a patient in a medical institution)." 42 U.S. C. § 1396d(a)(27)(A), 42 C.F.R. § 435.1008. A correctional facility is a "public institution" for purposes of this prohibition. 42 C.F.R. § 10009.

3. Letter from Donna E. Shalala, Secretary of Health and Human Services to Honorable Charles E. Rangel, House of Representatives (April 5, 2000); see also letter from Sue Kelley, Associate Regional Administrator, Division of Medicaid and State Operations to Kathryn Kumerker, Director, Office of Medicaid Management, New York State (September 20, 2000).

4. *Id.* Memorandum from the Director, Disabled and Elderly Health Programs Groups, Center for Medicare and Medicaid Operations, to All Associate Regional Administrative Divisions for Medicaid and State Operations, "Clarification of Medicaid Coverage Policy for Inmates of a Public Institution," Health Care Financing Administration, Department of Health and Human Services (December 12, 1997).

5. Moreover, a state may not terminate anyone from Medicaid without first determining whether the individual qualifies under other Medicaid-eligibility categories. See 42 C.F.R. § 435.930(b) (states must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible.").

6. Council of State Governments, Criminal Justice/Mental Health Consensus Project (June 2002), New York: Council of State Governments, at p. 109, n. 32 (citing a report of a survey of states in which all but one reported a policy of terminating enrollment in Medicaid upon a person's incarceration: Collie Brown, "Jailing the Mentally Ill," *State Government News*, April 2001, p. 28). The report may be found at www.consensusproject.org. See also Lackey, Cindy, Final Results of State Medicaid Agencies Survey in Memorandum to Fred Osher, Director of Center for Behavioral Health, Justice and Public Safety (October 16, 2000). Many management information systems are set up so that termination is the only option to prevent federal financial participation for incarcerated individuals.

7. Council of State Governments, Policy Statement 13(f) at p.108. As the report notes, "Suspending, instead of terminating, the detainee's enrollment in Medicaid enables staff to effect the reinstatement of the benefits immediately upon release, guaranteeing the individual access to the treatment and medications likely to keep him or her from coming into contact with the criminal justice system again." *Id.*

8. Letter from Donna E. Shalala, Secretary of Health and Human Services to Honorable Charles E. Rangel, House of Representatives (April 5, 2000); letter from Sue Kelley, Associate Regional Administrator, Division of Medicaid and State Operations to Kathryn Kumerker, Director, Office of Medicaid Management, New York State (September 20, 2000); see 42 C.F.R. § 435.930 (a) (states must "furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures").

9. Letter from Tommy Thompson, Secretary, U.S. Department of Health and Human Services, to Congressman Charles Rangel (October 1, 2001); letter from Sue Kelley, Associate Regional Administrator, Division of Medicaid and State Operations to Kathryn Kumerker, Director, Office of Medicaid Management, New York State (September 20, 2000).

10. In 32 states, SSI eligibility results in automatic Medicaid coverage; in seven other states, SSI recipients are automatically eligible for Medicaid but must submit a separate application. In the 11 states that use different rules (CT, HA, IL, IN, MN, MS, NH, ND, OH, OK and VA), people who receive SSI nearly always qualify for Medicaid, although they must go through a separate application process.

11. Before ending someone's Medicaid eligibility, states must determine whether the individual qualifies for Medicaid under any of the state's eligibility categories. See 42 C.F.R. § 435.930(b).

12. 20 C.F.R. § 416.211(a).

13. However, reinstatement of SSI requires submission of evidence that the individual again meets the financial requirements for the program. Cf. 20 C.F.R. § 416.1321(b).

14. 20 C.F.R. § 416.1335.

15. 42 U.S.C. § 402(x)(1)(A)(i). SSDI benefits are suspended for any 30-day period during which an individual is confined in a jail or prison in connection with a verdict or finding of not guilty by reason of insanity or guilty but insane with respect to a criminal offense, or a finding of incompetence to stand trial. 42 U.S.C. § 402(x)(1)(A)(ii); POMS DI 23501.000(A)(3). "POMS" refers to the Social Security Administration's Program Operations Manual System, available online at SSA's website, http://policy.ssa.gov/poms.nsf.

16. See Social Security Handbook (2001) § 0505E (imprisonment for conviction of a felony results in benefits not being paid) and § 0506 (last month of entitlement to SSDI generally occurs when disability ends, individual reaches age 65 or individual dies). Cf. § 1851 (listing events that end entitlement to benefits).

17. 42 U.S.C. § 402(x).

Article IV: Applications for Inmates with Psychiatric Disabilities Terminated from or Not Enrolled in Federal Benefit Programs

A. State Policy

It shall be the policy of [State] to assist inmates with psychiatric disabilities whose eligibility for SSI, SSDI or Medicaid benefits was terminated while incarcerated or who were not receiving benefits at the time they were incarcerated to apply, while incarcerated, to receive benefits upon release.

B. Medicaid

1. The [Medicaid agency] shall:

a. establish procedures for receiving Medicaid applications on behalf of incarcerated individuals with psychiatric disabilities in anticipation of their release.

b. expeditiously review such applications and, to the extent practicable, complete its review before the individual is released. All reviews shall be completed within fourteen (14) days of the application's receipt.

2. The review process shall assess whether the individual is presently eligible to be enrolled in the Medicaid program or is likely to be Medicaid eligible upon release.

Commentary on Article IV

IV. A. State Policy

This article mandates that individuals whose benefits have been terminated or who were never on benefits will receive assistance, as needed, in applying for benefits prior to release. The Council of State Governments Consensus Project urges states to "establish a process through which the state Medicaid agency will accept applications from inmates while they are still in custody and will process these applications in a timely manner to ensure that those found potentially eligible are then able obtain access to the benefits immediately upon release."[1]

IV. B. Medicaid Application Procedures

Medicaid application-processing systems, which differ from state to state, will need to be changed so that they can expeditiously receive and consider applications from inmates who are preparing for release.

Examples:

- In Colorado, legislation effective January 1, 2003 provides that inmates who were eligible for Colorado's Medicaid program at the time they were incarcerated or who are reasonably expected to meet eligibility criteria must be given assistance in applying for Medicaid at least 90 days prior to release.[2] The Department of Health Services must promulgate rules to simplify the application process and help correctional facilities implement the law, including by providing training on Medicaid eligibility. If a person is found to be eligible, the county department of social services must enroll the inmate upon release and at the time of release must give the inmate information about how to access medical assistance.[3]
- New York State-Access to Medicaid: A program in the Albany jail, the state's fifth largest, has improved discharge planning for individuals with psychiatric disabilities. County social services staff assist individuals with applications for Medicaid benefits, which are filed 45 days prior to the anticipated date of release. Applications are registered and logged and held for activation upon the individual's release. When released, the inmate goes to the social services office to verify information. The social services office not only processes the Medicaid application but also assists the released individual in other ways, including help with searching for a job and accessing food stamps, general assistance and other programs.[4]

- New York City: Pursuant to a consent decree approved by the court on April 2, 2003, New York City will provide assistance to inmates with mental illnesses in securing entitlements and obtaining treatment and other services when they are released from jails. Medicaid benefits are to be reactivated for any class member who had active Medicaid benefits in the 12 months prior to his or her known or projected release date. Those whose Medicaid benefits are to be reactivated upon release must have a permanent or temporary (as appropriate) Medicaid card at the time of release or mailed to an address he or she provides. Each individual who appears eligible for Medicaid but whose Medicaid benefits have not been activated or reactivated as of release will be enrolled in the state's Medication Grant Program or otherwise given means to pay for any psychotropic medications.[5]

IV. C. Applying for Federal Disability Benefits

An inmate can begin receiving benefits in the first calendar month after the month during which he or she is released from incarceration. SSA will accept applications for SSI, SSDI and Food Stamps prior to an individual's release. See Commentary to Article V.B. regarding SSA Pre-Release Agreements.

a. If the individual is eligible to be enrolled while incarcerated, the individual will be enrolled but placed on suspended status. The individual will be provided a Medicaid card, entitling the individual to receive benefits effective upon his or her release.

b. If the individual is not eligible to be enrolled in Medicaid while incarcerated but is likely to be eligible for Medicaid upon release, the individual will be enrolled in the temporary Medicaid eligibility program described in Article VI. B., but on suspended status pending release. The individual will be provided a Medicaid card, entitling the individual to receive benefits under the temporary Medicaid eligibility program effective upon his or her release.

3. To facilitate enrollment in Medicaid, [correctional agencies] shall:

a. identify inmates with psychiatric disabilities who are likely to be eligible for Medicaid while incarcerated or upon release, and ask them if they wish to receive benefits when released, and

b. for those who wish to receive benefits, ensure that (i) applications for Medicaid are filed, to the extent practicable, well in advance of release and, if possible, at least ninety (90) days before release, and (ii) all applicants for these benefits leave the correctional institution with a copy of the application.

1. Council of State Governments, Criminal Justice/Mental Health Consensus Project (June 2002), New York: Council of State Governments, at p. 169. The report may be found at www.consensusproject.org.

2. House Bill 02-1295, General Assembly of Colorado, amending Colorado Unified Code of Corrections, 1730 ILCS 5/3-17. The bill applies to inmates of correctional facilities and community correctional programs. It provides protections for inmates whose SSI or SSDI cash benefits have been suspended and inmates who are reasonably expected to meet SSI/SSDI eligibility criteria upon release.

3. *Id.*

4. Bazelon Center for Mental Health Law, *A Better Life—A Safer Community: Helping Inmates Access Federal Benefits* (March 2003) at 12-13, issue brief available at www.bazelon.org/issues/criminalization/publications/gains.

5. The city signed th[e] agreement to settle a class-action lawsuit brought on behalf [of] New York City jail inmates with mental illness, who were typically [re]leased from jail in the middle of the night with no more than $1.50 and two subway tokens. In an earlier ruling in the case, the court had ordered the city to provide "adequate discharge planning." The court noted that without such planning, inmates risk "a return to the cycle of likely harm to themselves or and/or others" and re-arrest. *Brad H. v. City of New York*, 185 Misc.2d 420, 431 (N.Y. Sup. Ct. 2000), aff'd, 276 A.D.2d 440 (N.Y. App. Div. 2000).

C. Disability Benefits

[Correctional agencies] shall seek to ensure that inmates with psychiatric disabilities begin to receive SSI and SSDI cash benefits for which they are eligible in the month following release. To this end, these agencies shall:

1. identify inmates with psychiatric disabilities who are likely to be eligible for SSI or SSDI upon release and ask them if they wish to receive benefits when released, and

2. for those who wish to receive benefits, ensure that applications are filed on their behalf prior to release and, to the extent practicable, at least ninety (90) days before release, and that they leave jail or prison with a copy of the application.

Commentary on Article V

V.B. Pre-Release Agreements

This section of the Model Law directs correctional agencies to use their best efforts to negotiate pre-release agreements with the Social Security Administration. The deadline for concluding negotiations should be inserted in Article XI.2.

A pre-release agreement is an agreement between a correctional agency and the Social Security Administration (SSA) to cooperate in the processing of SSI applications under SSA's "pre-release procedure,"[1] which is designed to "assur[e] eligible individuals timely SSI payments when they reenter the community."[2] Under this procedure, SSA (a) processes SSI applications from incarcerated individuals months before their anticipated release and (b) makes a prospective determination of potential eligibility and payment amount, based on anticipated circumstances.[3] Through this approach, SSI cash benefits are payable as soon as feasible after—sometimes even on the day of—release.[4]

Pre-release agreements can be written or verbal,[5] and can apply to one correctional facility, a group of facilities, or all the facilities in a jurisdiction.[6]

The SSA will process an application under the pre-release procedure for "those who:

- appear likely to meet the criteria for SSI eligibility when they are released from the institution, and
- may potentially be released within 30 days after notification of potential SSI eligibility."[7]

Both sides make commitments. The correctional agency agrees to:

- identify and notify SSA of inmates who (a) are likely to meet SSI eligibility criteria upon release and (b) may potentially be released within 30 days of SSA's making a prospective eligibility decision;[8]
- designate, for each correctional facility, a facility liaison to handle all referrals and to work with the local SSA office;
- provide current medical evidence and non-medical information that may support the inmate's claim;
- provide the anticipated release date; and
- notify SSA if that date changes and when the inmate is actually released.

In return, SSA agrees to:

- train facility staff about SSI rules and work with them to ensure that application procedures work smoothly;
- provide a contact person at Social Security to assist

facility staff with the pre-release procedure;
- process new applications and re-applications in an expeditious and timely manner;[9] and
- promptly notify the facility of its decision on the inmate's eligibility.[10]

When the inmate is released, SSA verifies the individual's living arrangement, makes a final adjudication of the claim and initiates payment, all of which can be done expeditiously.[11]

A pre-release agreement works best when the office that makes the initial disability determination, the state's Disability Determination Service, is involved in its crafting.

A model pre-release agreement created by SSA can be found at POMS SI 00520.930 Exhibit 2.

Pre-release agreements may also be used to improve access to SSDI and to Food Stamps. Although the use of pre-release agreements to speed access to SSDI is not specifically mentioned in the statute or POMS, jurisdictions have negotiated such agreements with SSA. The pre-release procedure can be used to expedite an application for Food Stamps at the same time. Congress recently took steps to assure that inmates could apply for Food Stamps as well as SSI under SSA's pre-relase procedure.[12]

Correctional agencies can take advantage of SSA's pre-release procedure without entering into a pre-release agreement.[13] However, it is preferable to have a pre-release agreement in place, for clarity about process and about the commitments made both by SSA and by the correctional agency.[14]

Example:
- Texas: Pursuant to a pilot pre-release project, federal benefit applications for SSI, SSDI and/or Food Stamps are submitted from correctional facilities to SSA 90 days prior to an inmate's release from custody. Inmates who go through this process typically receive their disability checks very quickly upon release. The state provides a stipend to released inmates, which helps until the checks begin. The SSA regional office provided training to local SSA staff, who at first resisted the new process and did not fully understand SSA's rules regarding inmates. Physicians at corrections facilities received training from SSA to help them provide the appropriate medical information concerning inmate's disabilities. The approval rate of such applications "has increased by 27% since the inception of the program," for which credit is given to "a well-trained and knowledgeable staff whose sole function is to expedite the Social Security application process."[15] "The financial benefit to local and state government is without question a positive

Article V: Facilitating Applications for Benefits

A. State Policy

It shall be the policy of [State] for correctional agencies to enter into Pre-Release Agreements with the Social Security Administration and to otherwise facilitate participation by inmates with psychiatric disabilities in federal benefit programs upon their release from incarceration

B. Negotiating Pre-Release Agreements with Social Security Administration

1. [Correctional agencies] shall use their best efforts to negotiate Pre-Release Agreements with the Social Security Administration that will ensure:

a. speedy consideration by the Social Security Administration of new applications for and applications for reinstatement of SSI or SSDI on behalf of individuals with psychiatric disabilities, and that

b. the Social Security Administration is informed of the expected and actual release dates of individuals with psychiatric disabilities whose applications have been approved or are pending.

2. Once negotiated, each agreement shall be implemented as soon as practicable.

C. Application Assistance

1. Competent staff familiar with the characteristics of successful SSI, SSDI and Medicaid applications shall ensure that proper applications are filed and updated as needed. These staff will, among other things:

a. with applicants' assistance, complete required forms for applicants with psychiatric disabilities;

b. with applicants' consent, secure medical and other information required to support applications; and

c. submit applications to the appropriate agency office.

These staff may be provided through contracts with local mental health agencies or providers.

2. With the applicant's permission, a copy of each application shall be provided to a family member designated by the applicant and to any mental health case manager who will work with the individual upon release. Permission to provide a copy to a parent is not required in the case of minors under the age of 16.

outcome of the pilot. Another anticipated outcome is a more successful re-entry into the community once the offender is released from incarceration."[16]

- Oklahoma: In partnership with SSA, the Medical Services Division of the Oklahoma Department of Corrections has initiated a program to connect inmates with SSA benefits prior to release in two state facilities (one for males with development delays and one for female inmates). The new program includes only inmates who were eligible for Social Security when they became incarcerated and those who are over 65. A "reintegration specialist" at each facility works with a counterpart at the local SSA office to pull together applications.[17]

V. C. Application Assistance.

The model law imposes on staff the obligation to complete applications, with the help and consent of the applicant. Alternatively, drafters might impose the obligation on the applicants themselves, directing that staff help them as desired. Typically, successful programs use staff to complete applications.

The model law does not identify the entity that will employ and train staff; however, it indicates that staff may be provided through contracts with local mental health agencies or providers. Providing application assistance through mental health case managers would be a good choice. The best approach may be to use staff who already have substantial benefits expertise, such as staff from the state mental health agency, public or private community-based mental heath providers, the state Medicaid agency or the state welfare agency. For such staff to work successfully within correctional settings, corrections officials must be receptive, cooperate fully and provide orientation and training so that the benefits staff will understand how to work within a jail or prison environment.

Federal Medicaid law directs that individuals be permitted to have assistance in applying for benefits.[18] Federal Medicaid dollars may be used to pay for costs incurred in helping individuals to complete Medicaid applications, at the normal Medicaid match.[19] The Americans with Disabilities Act requires that individuals with psychiatric disabilities be aided in completing applications for public benefits.

1. 42 U.S.C. § 1383(m) (SSA "shall develop a system under which an individual can apply for supplemental security income benefits [SSI] ... prior to the discharge or release of the individual from a public institution"), POMS SI 00520.910 B. "POMS" refers to the Social Security Administration's Program Operations Manual System,

available online at SSA's website, http://policy.ssa.gov/poms.nsf.

2. POMS SI 00520.900 A; POMS DI 23530.001 A (pre-release procedure designed "to ensure title XVI funds are made available immediately upon an individual's release"). See POMS SI 00520.900 B ("The prerelease procedure applies to penal institutions, as well as other public institutions.").

3. "The distinguishing feature of the prerelease procedure is that it allows for the taking and processing of an SSI application for an institutionalized individual several months before his anticipated release. Furthermore, it allows for a prospective determination of potential eligibility and payment amount, based on anticipated circumstances. The procedure is intended to serve individuals who, because they are institutionalized, are currently ineligible for SSI...In addition to helping those who have never received SSI, the provision can also facilitate a reinstatement after suspension." POMS SI 00520.900 A.

4. When SSI benefits are suspended, they can be reinstated immediately upon release. 20 C.F.R. § 416.1325. When SSI benefits have been have been terminated, or a new application is made, cash benefits cannot begin until the month following the month of the inmate's release (i.e., the first full calendar month following release). 20 C.F.R. § 416.211(a)(1).

When suspended beneffits are restored immediately upon release, the inmate receives a pro-rated cash benefit for the month of release (i.e., the cash benefit is pro-rated for the portion of the month the inmate is "on the outside"). 20 C.F.R. § 416.421.

5. "An agreement may be formal (a written agreement signed by both parties), or informal." POMS SI 00520.910 B.2

6. POMS SI 00520.910 B.1 ("The parties to a prerelease agreement are [SSA] and the institution (or the agency which administers more than one institution."); see also POMS SI 00520.910 B.3.

7. POMS SI 00520.900 B

8. It is important to know how long it might take SSA to process an application and make a prospective eligibility determination. The POMS indicate that "if a release date within the life of the application is likely, [SSA] will hold the claim until release. If not, ...[SSA] will take final action to disallow the claim." POMS SI 00520.920 C.2.b; POMS SI DI 23530.001 D.4 (when an inmate is not released within "a specified time period (preferably 30 days) but release within the life of the application is *likely*, [SSA] holds the claim until release. If release *not likely* within the life of the application, [SSA] takes final action to deny the case on technical basis.") (emphasis in original).

9. POMS SI 00520.910 B.4. See also POMS DI 23530.001 B ("For all applications received under the prerelease procedure, SSA will *expedite determinations* of SSI eligibility and payment amount."); POMS SI 00520.900 C.2 (same); POMS SI 00520.930 at 2 (SSA will "[p]rocess all prerelease claims in an expeditious and timely manner").

10. POMS SI 00520.920 C.1.a (SSA will "[n]otify institutions of the determination of potential eligibility as soon as possible"); see POMS SI 00520.920 C.1.c ("When ... [an inmate] files, [SSA will] issue an informal notice to the institution to let the institution know as quickly as possible whether payments can be expected, so that release planning can continue.").

11. POMS SI 00520.920 A.6 ("When the person has actually been released from the institution, recontact the person to verify the living arrangement, adjudicate the claim and, if eligible, initiate payment.") See also POMS SI 00520.920 C.2.c-d.

12. 42 U.S.C. §1383(n) ("The Commissioner of Social Security and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under ... [SSA's pre-release procedure] shall also be permitted to apply at the same time for participation in the food stamp program authorized under the Food Stamp Act of 1977 (7 U.S.C. § 2011 et seq."). Some guidance on implementing this obligation is set out at 7 C.F.R. § 273.2(l) and POMS SI 01801.005, SI 01801.275, and SI DAL01801.020. The guidance is less than clear.

13. POMS SI 00520.900 C.1 (SSA will accept benefits applications under the pre-release procedure "without regard to whether a pre-release agreement exists"); POMS SI 00520.910 ("a formal agreement is not a prerequisite for utilizing prerelease procedure").

14. *Id.* ("a formal agreement...is a highly desirable means of ensuring understanding by all parties.").

15. The improved process for benefit access is part of a broader initiative for release planning and follow-up community care. The Texas Council has contracted with local mental health and human services agencies for staff to visit inmates six months prior to release, to engage in pre-release planning, help inmates access benefits and either provide follow-up care (when the inmate is released into the same community as the corrections facility) or arrange follow-up care in the inmate's home community (for those sent to corrections facilities in other parts of the state). For more information, the program's website is http://www.tdcj.state.tx.us/tcomi/tcomi-home.htm. The Biennial Report of the Texas Council on Offenders with Mental Impairments, Submitted to the Governor, Lieutenant Governor, Speaker of the House (2003), at 26-27.

16. *Id.* at 28.

17. "Oklahoma DOC Partners with Social Security Administration to Benefit Inmates," The Corrections Connection Health Care Network at www.corrections.com; also at the state's Department of Corrections website, www.doc.state.ok.us.

18. 42 C.F.R. § 435.908 (state must allow individual to bring someone to assist in the application process). See *Mount Sinai Hosp. v. Kornegay*, 347 N.Y.S. 2d 807 (N.Y. Civ. Ct. 1973) (finding affirmative duty of hospital to assist participant in applying for Medicaid benefits). See also 42 U.S.C. §1396a(a)(19) (state plan must provide safeguards necessary to ensure that eligibility will be determined and services provided consistent with the best interests of recipients).

19. 42 C.F.R. § 436.1001 (providing that federal financial assistance is available to cover necessary administrative costs incurred in determining eligibility).

Article VI: Bridge Programs

A. State Policy

It shall be the policy of [State] to offer individuals with psychiatric disabilities temporary Medicaid eligibility and temporary income support when released from incarceration while their applications for federal benefits are pending.

[Medicaid agency] will administer the temporary Medicaid eligibility program, and [state agency] will administer the temporary income support program.

B. Temporary Medicaid Card

1. An individual with psychiatric disabilities shall be qualified to receive a temporary Medicaid card upon release from incarceration if:

a. the individual is not receiving Medicaid-funded services;

b. the individual is likely to be eligible for Medicaid; and

c. an application for SSI or Medicaid was filed on his or her behalf while the individual was incarcerated or within three (3) months after the individual's release.

2. An individual with a psychiatric disability may apply for a temporary Medicaid card while incarcerated or within three (3) months after release. Application may be made by submission

Commentary on Article VI

Even when the state adopts all of the policies and processes set forth in Articles III-V to facilitate and expedite access to benefits, some inmates may nevertheless end up released and in the community without benefits. This might result from their being released earlier than expected because of the progress of their legal cases, or from processing delays by SSA, errors in identifying potentially eligible inmates and completing applications, or other unanticipated circumstances.

This article creates bridge programs to keep such individuals from falling through the cracks. The bridge programs are available to released inmates who have applied for federal benefits but whose applications are still pending. Released inmates qualify for the bridge programs if their applications for federal benefits were filed during incarceration or within three months of their release. The bridge programs provide temporary health care coverage and income benefits during the period that federal benefit applications are pending. Without bridge programs, many released inmates will lack access to health care coverage and income support and be at risk of decomposition and re-offending.[1]

VI. B. Temporary Medicaid

Regardless whether the inmate has ever before been a Medicaid recipient, states have the flexibility under federal law to place potentially eligible individuals in their Medicaid program, pending full review of eligibility. Initially, the cost of Medicaid services must be borne by the state, but once an individual's Medicaid eligibility is confirmed, the state may seek reimbursement from the federal government for services rendered before the eligibility determination.[2] Reimbursement will be made in accord with the state's match arrangement.[3]

Allowing for quick access imposes some financial risk on the state because some individuals enrolled in the temporary Medicaid program may ultimately be found ineligible for Medicaid. However, the state incurs a greater risk from the recidivism that often results when released inmates do not have access to appropriate mental health services.[4]

VI. C. Temporary Income Support

Many inmates with psychiatric disorders depend on SSI or SSDI to secure stable housing. Without stable housing, released inmates are at risk of decomposition and re-

offending. As the Council of State Governments Consensus Project notes, "[a]dequate housing is the linchpin of successful reentry for offenders with mental illness."[5]

When SSI or SSDI cash benefits are not immediately available, temporary income support should be provided to assist released inmates in securing housing and other necessities.

Temporary income support may be provided by putting individuals on state General Assistance in states that have such a program, or through a new program. The model law directs that payments be equal to the basic SSI payment in the state. A less costly, but considerably less effective, alterative would be to make payments equal to the General Assistance rate.

To the extent permitted by federal law, states may recoup support payments made to released inmates from SSI and SSDI back benefits. Under the model law, to be eligible for the temporary income support program, an individual must have applied for SSI or SSDI. Once the individual's eligibility for SSI or SSDI is established, the individual will receive back benefits for the time following release during which the individual's SSI or SSDI application was pending.

The state may arrange with recipients of temporary income payments to be reimbursed from any SSI and SSDI back benefits the recipient receives.[6]

1. See Nelson, M., Deess, P., and Allen, C. *The First Month Out, Post-Incarceration Experiences in New York City* (New York, New York: Vera Institute of Justice, 1999).

2. 42 U.S.C. § 1396a(a)(34), 42 C.F.R. § 435.914.

3. In all states, the federal government pays at least 50% of the cost of the Medicaid program. The actual proportion of costs paid by the federal government depends on the economic well-being of the state's population: the poorer the state, the higher the proportion of costs paid by the federal government. In the poorest states, the federal government pays approximately 75% of the cost of Medicaid services. POMS SI 01715.001 B ("The Federal government pays 50 percent of Medicaid administrative costs and between 50 and 83 percent of program costs following a statutory cost-sharing formula.") "POMS" refers to the Social Security Administration's Program Operations Manual System, available online at SSA's website, http://policy.ssa.gov/poms.nsf.

4. See discussion of costs in the commentaries on Articles I and X.

5. Council of State Governments, Criminal Justice/Mental Health Consensus Project (June 2002) at p. 167. Also, "housing is crucial for helping individuals with mental illness maintain stability and avoid involvement in the criminal justice system." *Id.* at p. 110.

6. We are unaware of any federal law that would bar such an arrangement. See *Washington State Dept. of Social and Health Services v. Guardianship Estate of Keffeler*, -- U.S. --, 123 S.Ct. 1017 (2003) (state may recoup foster care expenditures from children's SSI and SSDI benefits).

to the [Medicaid agency] of an application for Medicaid, a copy of an application for SSI submitted on the individual's behalf or other documentation deemed suitable by the [Medicaid agency].

3. Within fourteen (14) days of submission of the application, the [Medicaid agency] will determine whether the individual is qualified to receive a temporary Medicaid card and, if so, will immediately issue a temporary Medicaid card to the individual. If the individual is incarcerated, the card will entitle the individual to receive benefits under the temporary Medicaid program effective upon his or her release. If the individual has already been released, the card will be effective immediately.

4. If found qualified for a temporary Medicaid card, the individual is entitled to receive covered Medicaid services from certified Medicaid providers for a period of six (6) months. For individuals found qualified while incarcerated, the six (6) months begins upon release. For individuals found qualified after release, the six (6) months begins on the date of that determination. The six (6) month term may be renewed at the option of the [Medicaid agency].

5. A temporary Medicaid card shall be void if, prior to the end of a six (6) month term, it is determined that:

a. the individual is not eligible for the SSI program, and

b. the individual is not eligible for Medicaid under any other Medicaid eligibility category.

6. To the extent permitted by federal law, the state may claim reimbursement under the Medicaid program for payments made for care provided to an individual to whom a temporary Medicaid card has been issued. The state may not recoup any costs from the individual, including if the individual is found ineligible for Medicaid.

C. Temporary Income Support

1. An individual with a psychiatric disability shall be qualified for temporary income support upon release from incarceration if:

a. the individual is not receiving SSI or SSDI;

b. the individual is likely to be eligible for SSI or SSDI, and

c. an application for SSI or SSDI was filed on his or her behalf while the individual was incarcerated or within three (3) months after the individual's release.

2. An individual with a psychiatric disability may apply for temporary income support while incarcerated or within three (3) months after release. Application may be made by submitting to the [responsible agency] a copy of an application for SSI or SSDI benefits, or other documentation deemed suitable by

the [responsible agency]. Within fourteen (14) days of submission of the application, the [responsible agency] will determine whether the individual is qualified to receive temporary income support.

3. Temporary income support shall be paid monthly in an amount equal to the [basic SSI payment in the state]. Payments will be made for a period of six (6) months. For individuals found qualified while incarcerated, the six (6) months begins upon release. For individuals found qualified after release, the six (6) months begins on the date of that determination. The six (6) month term may be renewed at the option of the [responsible agency]. Payments may be terminated before the end of a six (6) month term if the Social Security Administration makes a final determination that the individual is not eligible to receive the federal benefits for which the individual applied.

4. To the extent permitted by federal law, the state may recoup the temporary income support from SSI or SSDI back benefits issued by the Social Security Administration. The state may not otherwise recoup any payments of temporary income support from the individual, including if the individual is found ineligible for SSI or SSDI.

Article VII: Photo Identification

[Correctional agencies] shall arrange for adults and emancipated youth with psychiatric disabilities to have photo identification when they are released from incarceration. [Correctional agencies] will ensure that inmates who lack photo identification are issued a photo identification card before or immediately upon release. The photo identification card will not disclose the individual's incarceration or criminal record. It will list an address other than a correctional facility.

Commentary on Article VII

Photo identification is necessary for adults and emancipated minors because it is required to conduct so many daily transactions. Applications for benefits require proof of identity, as do many basic activities, such as cashing a check.[1] Often, whatever ID an inmate had prior to incarceration has been lost. This section mandates the provision of some sort of official, government-issued identification card, such as a non-driver's ID, for every individual leaving a correctional facility for the community. The ID provided should be generic and not in any way identifiable with the correctional system.[2]

1. Nelson, M., Deess, P., and Allen, C. *The First Month Out, Post-Incarceration Experiences in New York City*, at p. 30 (New York, New York: Vera Institute of Justice, 1999).

2. The Council of State Governments Consensus Project report states: "Corrections administrators should also assist inmates in applying for state identification cards, which will be provided upon the inmate's release. Without such proof of identification, it is nearly impossible for a person to avail him or herself of many benefits or services." Council of State Governments, Criminal Justice/Mental Health Consensus Project (June 2002) at p.169.

Commentary on Article VIII

This article is designed to promote and ensure continuity of mental health care for individuals involved in the criminal justice system. It requires that, when incarcerated, individuals with psychiatric disabilities have access to necessary mental health services (including substance abuse treatment), particularly counseling, crisis services and appropriate medications.[1]

In a departure from usual practice, the model law imposes on the mental health system the responsibility for providing such care to individuals in jail or juvenile detention facilities. Such an arrangement, in our view, will promote better care, and continuity of care, for those incarcerated pre-trial o sentenced to jail for minor offenses, who generally stay in jail less than a year and often for relatively brief periods.

The model law also imposes on the mental health system the obligation to provide case management services to inmates, focused on release planning (akin to discharge planning in the mental health system).This obligation extends to all inmates, not just those in jails and juvenile detention facilities. Essential release-planning activities include: identifying community-based service providers that can meet the needs of the individual upon release, arranging for the individual to be linked with providers upon release, facilitating access to benefits programs, and helping to locate and secure suitable housing for the individual upon release.[2] (Case management services should continue after release, and can be financed through Medicaid.)[3]

The model law requires that, when released, inmates be given a 14 day supply of medication and access to Medicaid.[4] In the community mental health system, prescriptions are typically for a 30 day supply. The shorter time period is meant to encourage a visit with a psychiatrist and a medication review shortly after release.

- The Texas Council's Continuity of Care (COC) Program provides formal pre- and post- release aftercare for all offenders with special needs released from Texas Department of Criminal Justice Facilities (including state jails and prisons). COC staff develop pre-release plans in conjunction with community service providers who will work with the individual following release. In addition, 90 days prior to release, Benefit Eligibility Specialists initiate all relevant applications for federal entitlements for which the inmate may be eligible (SSI, SSDI, Food Stamps, etc.).[5]

Article VIII: Access to Services

A. State Policy

It is [State's] policy that inmates have access to mental health services while incarcerated and upon release, as provided below.

1. For individuals in prison who have psychiatric disabilities, the [state corrections agency] shall be responsible for the provision of mental health services.

2. For individuals in juvenile corrections facilities who have psychiatric disabilities, the [state juvenile corrections agency] shall be responsible for the provision of mental health services.

3. For individuals in jail or juvenile detention facilities who have psychiatric disabilities, the [state mental health agency] shall be responsible for the provision of mental health services.

4. The [state mental health agency] shall be responsible for the provision of the case management services described in (C.) below.

These agencies may arrange for services to be provided through contracts with community mental health agencies or community mental health providers.

B. Mental Health Services

1. While incarcerated, individuals with psychiatric disabilities shall have access to medically necessary mental

health services, including substance abuse and crisis services.

2. At the time of their release, individuals with psychiatric disabilities shall be provided a fourteen (14) day supply of the psychiatric medications they were taking prior to release.

3. Individuals with psychiatric disabilities shall be given access upon release to Medicaid-covered services as provided in Articles III, IV and VI.

C. Case Management Services

1. To aid their transition to community living, the [state mental health agency] shall provide to incarcerated individuals with psychiatric disabilities case management services well in advance of their release, to the extent practicable, and if possible, at least ninety (90) days before release.

2. The case manager shall work with the individual to identify services and supports that the individual desires and needs upon return to community living. As desired by the individual, the case manager will:

a. help arrange for needed shelter, mental health services including substance abuse services and other supports to be provided to the individual upon release; and

b. help the individual access federal benefit programs upon release, including, as needed, by updating benefit applications.

At least two court decisions recognize inmates' right to continuity of care upon release from incarceration.

- A federal appeals court (covering California, Oregon, Washington, Arizona, Montana, Idaho, Nevada, Alaska and Hawaii) has ruled that the U.S. Constitution requires states to ensure that a released inmate who has been receiving medication while incarcerated leaves the facility with "a supply sufficient to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply."[6]
- Relying on state law, a judge ordered New York City to provide "adequate discharge planning" to individuals who have mental illnesses, to avoid "a return to the cycle of likely harm to themselves and/or others" and resulting arrest.[7]

1. According to the Council of State Governments Consensus Project report, states should "[e]nsure that the mechanisms are in place to provide for...crisis intervention and short-term treatment, and discharge planning for defendants with mental illness who are held in jail pending the adjudication of their cases," Council of State Governments, Criminal Justice/Mental Health Consensus Project (June 2002), Policy Statement 13, page 102, and "[f]acilitate a detainee's continued use of medication prescribed prior to his or her admission into the jail," *id.*, Policy Statement 13(e), at p. 107.

2. The Council of State Governments Consensus Project notes that "[r]eaching out to community-based organizations and agencies that would serve this population and facilitating their access to the institution/inmate prior to release will enhance the likelihood that an individual, upon release, would seek out services." Report at p. 171. It urges states to "[i]mprove availability of and access to comprehensive, individualized services when and where they are most needed to enable people with mental illness to maintain meaningful community membership and avoid inappropriate criminal justice involvement." *Id.*, Policy Statement 1, p. 28. To this end, the Consensus Project recommends that states "[p]rovide user-friendly entry to the mental health system for those who need services," *Id.*, Policy Statement 1(a), p. 28, and "[f]acilitate collaboration among corrections, community corrections, and mental health officials to effect the safe and seamless transition of people with mental illness from prison to the community," *Id.*, Policy Statement 21, p. 162.

3. The Council of State Governments Consensus Project notes that "[f]or inmates with mental illness, whose community adjustment issues are even more complex than inmates in the general population, the need for systemic discharge planning is particularly crucial." *Id.*, at p. 162. "One particularly promising, albeit uncommon, strategy is to have the transition planner working with the inmate during the last months of his or her incarceration continue as a case manager (coordinating the delivery of services and facilitating the person's compliance with conditions of release) after the offender's release to the community. As part of such a strategy, community-based staff, who will eventually provide post-release case management, can be brought into the institution to work with institutional-based discharge planners in devising and carrying out a comprehensive case management plan." *Id.*, at p. 163.

4. The Council of State Governments Consensus Project urges states to provide "an adequate supply of essential psychotropic medications upon ...release"). *Id.*, at p. 168

5. Biennial Report of the Texas Council on Offenders with Mental Impairments, Submitted to the Governor, Lieutenant Governor, Speaker

of the House (2003) (available at http://www.tdcj.state.tx.us/tcomi/tcomi-home.htm), at 20.

6. *Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999).

7. *Brad H. v. City of New York*, 185 Misc.2d 420, 431 (N.Y. Sup. Ct.), *aff'd*, 276 A.D.2d 440 (N.Y. App. Div. 2000).

Commentary on Article IX

The changes in Medicaid procedures described in the model law will not necessarily require amendments to the state's Medicaid plan. Much depends on the level of detail in the existing state plan. Upon enactment of the law, Medicaid officials should review the existing state plan and make any adjustments they find necessary.

Article IX: State Medicaid Plan

If implementation of any regulation or policy anticipated by this Act requires an amendment to the state Medicaid plan, the [Medicaid agency] shall use its best efforts to obtain federal approval of the amendment.

Article X: Funding

A total of $_____ is appropriated for implementation of this Act, as follows:

1. $_____ to [Medicaid agency] for implementation of Articles III, IV and VI;

2. $_____ to [corrections agencies] for implementation of Articles III, IV, V, VII and VIII;

3. $_____ to [responsible state agency] for implementation of Article VI.C; and

4. $_____ to [state mental health agency] for implementation of Article VIII.

Commentary on Article X

The proposals in this model law are designed to be cost-effective for states in the long run. Tax dollars are wasted when individuals with psychiatric disabilities leave correctional settings without access to health care and income supports. Lacking access to mental health services, housing and other needed supports, they often experience crises, deteriorate and end up in emergency rooms, psychiatric hospitals, jails or all three.

It is extraordinarily inefficient and expensive to provide care in this way. In King County, Washington, officials identified 20 individuals with mental illnesses who had been repeatedly jailed, hospitalized or admitted to detoxification centers. In the course of one year alone, providing emergency services to these 20 individuals cost the county about $1.1 million.[1]

Better care can be provided less expensively, as experience demonstrates. For example, a study of Chicago's Thresholds program, a community-based jail diversion program, documented substantial cost savings from public investment in community mental health care and housing for released inmates. During a year in the Thresholds program, the 30 program participants studied spent approximately 2,200 days less in jail than in the year preceding their participation, for savings of $70 per day plus the expense of arrest and booking. They also spent about 1,800 fewer days in public psychiatric hospitals, for savings of $500 per day. Thresholds costs around $26 per day.[2]

The model law recognizes that states will incur some expense to implement it. For example, by accelerating the receipt of federal benefits, states will also accelerate their costs in these programs (i.e., state Medicaid shares and state SSI supplements). In addition, training state workers and taking other steps required to ensure inmates access to benefits immediately upon release is not without cost.

The fiscal analysis of Colorado's 2002 benefit-reinstatement law provides some guidance on calculating implementation costs. In Colorado, participating state agencies estimated that staff training and benefit-application assistance could be provided by existing personnel at no additional cost. Additional Medicaid expenditures were anticipated. Colorado calculated these expenditures as follows: considering historical data, including typical delays in receiving benefits, analysts estimated the numbers of eligible inmates who, upon release, would more speedily receive benefits, the number of total additional months for

which benefits would be received, and the resulting state cost. Figuring that federal financial participation would cover half the cost, the required general fund appropriation for FY 2002-2003 was determined to be $122,564.[3]

1. Council of State Governments (June 2002), Innovative Programs' Impact on Costs and Public Safety, Criminal Justice/Mental Health Consensus Project, at p.13 (citing unpublished data provided by Patrick Vanzo, Section Chief, Crisis and Engagement Services, Mental Health, Chemical Abuse and Dependency Services Division, King County Dept. of Community and Human Services). New York: Council of State Governments. The report may be found at www.consensusproject.org.

2. Information available at www.thresholds.org. The Council of State Governments Consensus Project report and website contain information about other exemplary programs and their cost-effectiveness.

3. Colorado Legislative Council staff, State Fiscal Impact of HB02-1295 (2/16/02).

Article XI: Effective Dates

1. Articles III, IV and VII become effective _____ days after enactment. The [Medicaid agency] will adopt the policies and procedures required by Articles III and IV within _____ days after enactment. These deadlines shall be extended as needed pending federal approval of any necessary amendment to [state's] Medicaid plan.

2. Correctional agencies] will use their best efforts to conclude negotiations with the Social Security Administration, pursuant to Article V, within _____ days after enactment.

3. The temporary health insurance and income support programs described in Article VI will be implemented within _____days after enactment.

4. Article VIII will be implemented within ____ days after enactment.

Commentary on Article XI

States are facing difficult fiscal issues, and this model law can help relieve some of the pressures on corrections, law enforcement and public health budgets at these critical times. Implementation of the its provisions should be a priority and should occur as soon as possible.

- *New York City* agreed to implement, 60 days after court approval, a settlement agreement mandating the provision of a comprehensive range of discharge planning services, including benefit reinstatement, for individuals with mental illnesses who are inmates in city jails.[1]
- *Colorado's* 2002 benefit-reinstatement law, mandating that correctional facilities implement steps to facilitate benefit reinstatement for individuals leaving jails and prisons, became effective six months after passage.[2]

1. *Brad H. v. City of New York*, No. 117882/99 (N.Y. Sup. Ct. April 2, 2003) (consent decree).

2. C.R.S.A. § 17-1-113.5 (inmates held in correctional facilities) and C.R.S.A. § 17-27-105.7 (offenders held in community corrections programs).

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